FINAL DRAFT: Practice Guidance:

Good Practice in Prescribing and Medicines Management for Physiotherapists

THIS IS NOT A LIVE DOCUMENT AND REQUIRES LEGISLATIVE CHANGE BEFORE IT CAN HAVE EFFECT.
# Practice Guidance – Prescribing and Good Medicines Management for Physiotherapists

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THIS IS NOT A LIVE DOCUMENT AND WILL REQUIRE CHANGES TO LEGISLATION FOR ITS CONTENTS TO COME INTO EFFECT.
Foreword

I am delighted to introduce this impressive document, which I am sure will be of great value not only to physiotherapists but also to many other health professionals. The clarity and rigour of the guidance provides a sound framework for the professional conduct of all new prescribers. It will inspire confidence in patients, practitioners, employers and organisations.

The benefits of non-medical prescribing are now well established. It is safe, it enables effective care to be provided without delay and it is popular with patients. It also allows registered professionals to be responsible and accountable for the full range of clinical care that they carry out. This helps to clarify relationships within the clinical team and to confirm the role of the experienced allied-health professional.

The rise in the number of physiotherapist prescribers comes at a time when we anticipate extensive changes in the delivery of health care in England and Wales. The prescribing qualification applies to all professional practice, regardless of the setting in which it is offered. Physiotherapists will therefore be able to make full use of their skills and expertise within any health care delivery system and I hope that they will continue to play their part in promoting excellence in the planning and standards of care in their chosen specialities.

I offer my congratulations to all those who have participated in the production of this document which forms such a firm basis for current practice and future developments.

Dr. June Crown CBE
Introduction

This Medicines Practice Guidance booklet provides ‘good practice’ information. This should underpin the decision-making and actions of physiotherapists who are annotated with the Health Professions Council (HPC) either as independent and/or supplementary prescribers.

This document is ‘guidance’. ‘Guidance’ is information which a physiotherapist has a duty to consider and is expected to take into account as part of their decision making process. This document provides advice on the behaviours and conduct expected of physiotherapists who are annotated on the HPC register as a Supplementary and/or Independent prescriber. Throughout this document, the use of the word ‘must’ indicates a legal and/or regulatory requirement and describes a mandatory action and/or behaviour. The use of the word ‘should’ indicates behaviours and/or actions that would be expected to occur in all normal circumstances.

If a physiotherapist prescriber deviates from the guidance in this document, the clinical judgement for so doing should be carefully recorded. You should comply with this Practice Guidance, other guidance issued by the CSP, and with any statutory requirements applicable to your prescribing practice. Failure to do so may put your HPC registration at risk if concerns are raised about your fitness to practise. A physiotherapist prescriber will be expected to justify any decision to act outside the terms of this guidance, and in particular if the physiotherapist-prescriber undertakes a course of action not recommended by this guidance there must be robust reasons for doing so.

The advice in this document applies to all sectors of health and social care provision in the United Kingdom where prescribing activities occur, as permitted by the prescribing laws in each of the Home Countries separately. The law may not be comparable across England, Scotland, Wales and Northern Ireland. It is up to the individual to satisfy themselves of the law in the UK country in which they work and that good governance procedures are in place in their workplace setting.

At the current time, prescribing is not permitted by physiotherapists outside of the UK and therefore a physiotherapist permitted to independently and/or supplementary prescribe in the UK cannot perform this activity outside of UK jurisdiction.
Each section of this guidance carries equal weight and the document is not ordered in any priority order.

**Key Legislation and Definition of Terms**

Medicines use in the UK is controlled by a very clear framework governed by the terms of the Medicines Act 1968. Physiotherapist prescribers must be absolutely clear that they understand this framework and the differences between the five core frameworks for medicines use.

**Supply and Administration Frameworks**

The Patient Specific Direction (PSD) – A PSD is a written instruction from a prescriber for a medicine to be supplied and/or administered to a named patient. It relates to the relationship between the prescriber and another professional. It is not a prescribing tool for the physiotherapist. The physiotherapist must only supply and/or administer the medicine in accordance with the instructions that are written by the prescriber. It is not good practice for oral instructions to be acted upon except in emergencies.

The Patient Group Direction (PGD) – This is not a prescribing tool for the physiotherapist. A senior doctor and a senior pharmacist, in conjunction with the physiotherapists who will use the tool, define in writing the named medicines that may be supplied and/or administered to groups of patients who may, or may not have been, individually identified prior to treatment. The PGD must be drawn up in a specific way in order to be legally valid. The physiotherapist must supply and administer the medicine in accordance with the instructions that are written within the PGD. PGDs are not valid in all healthcare delivery settings. **The application of PGDs in clinical practice varies between the Home Countries.**

**Exemptions.** This is not a prescribing tool. Specific pieces of law allow certain listed medicines to be supplied and administered to patients by certain health professional groups without the need for another appropriate prescribing or supply/administration framework. There are no Exemptions that apply to physiotherapists.
Prescribing Frameworks

**Supplementary Prescribing** – It allows a physiotherapist to prescribe, as well as supply and administer medicines to individual named patients, those medicines that have been defined in writing within a Clinical Management Plan as appropriate to the needs of the named patient. Supplementary prescribing requires the involvement of an independent prescriber, the supplementary prescriber and the patient. The terms of use and definition of ‘clinical management plan’ are defined in law. For a CMP to be legally valid, the independent prescriber must only be a doctor or a dentist.

**Independent Prescribing** – It allows a physiotherapist to autonomously prescribe, as well as supply and administer medicines to individual named patients appropriate to the needs of the named patient. The requirements for non-medical independent prescribing are different to those for medical prescribing, therefore doctors and non-medical IP’s are not directly comparable in all their activities.

**Categories of Medicine**

**General Sales List medicines (GSL)**
These products can be sold with reasonable safety without the supervision or advice of a doctor or pharmacist, and may be obtained through a variety of outlets. All GSL medicines must hold a valid UK product licence and all the active ingredients must be listed in the product. Regulations (4) restrict the pack sizes and quantities of the medicine that may be sold without supervision. Larger volumes may only be sold under supervision (P class) or prescription (POM class). An example of this would be paracetamol that is limited to 16 tablets under GSL terms, but may be supplied in larger quantities under P or POM terms.

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1 The Medicines (Exemptions and Misc Amendments) Order 2009 SI 2009/3062
Pharmacy sale medicines (P)
These products can be sold with reasonable safety from premises that are under the supervision of a pharmacist but without the need for a written prescription. The products may be available for self-selection by the general public but a pharmacist is aware of the purchase at the point of sale.

Both GSL and P class medicines are known as ‘over-the-counter’ (OTC) medicines as they can be sold and supplied (in some cases only at certain low volumes) without a written prescription for supply.

Prescription Only Medicines (POM)
The Prescription Only Medicines (Human Use) Order defines those medicines that must be classed as POM if they:

- Contain certain listed substances
- Are controlled drugs
- Are for parenteral (i.e. injection) administration (with the exception of insulin)
- Emit radiation
- Other listed criteria

POMs may only be sold, supplied and administered in accordance with a written prescription by an appropriate practitioner and dispensed from a registered pharmacy or dispensing doctor’s practice.

Section 58(2) of The Medicines Act defines ‘appropriate practitioner’ for the purposes of issuing written prescriptions as:

- Doctor, dentist, vet
- Independent nurse prescriber
- Independent pharmacist prescriber
- Independent optometrist prescriber
- Supplementary prescriber acting under a written\(^\text{ii}\) Clinical Management Plan (CMP) - (nurse, pharmacist, midwife, podiatrist, physiotherapist, radiographer, optometrist)

\(^\text{ii}\) The term ‘Clinical Management Plan’ is now defined in law by Section 1(2) of The Medicines (Exemptions and Miscellaneous Amendments) Order 2009 (No. 3062)
A physiotherapist who is annotated on the Health Professions Council (HPC) register as a Supplementary Prescriber may prescribe POMs under a written Clinical Management Plan (CMP), and may prescribe them independently if they are annotated as an Independent Prescriber.

POMs are restricted to those patients that a health professional has identified as an appropriate recipient. Regulations require that POMs may not be advertised to the general public, only marketed to health professionals, and there is blanket ban on the advertising to the public of certain treatments for certain specified medical conditions such as cancer.

**Controlled Drugs**
The Misuse of Drugs Act 1971 controls certain types of drugs that may be liable to misuse and abuse because of their effects on users. Schedule 2 of this Act lists the drugs subject to these specific controls and it categories the drugs into one of three classes; Class A, Class B and Class C. The term ‘controlled drug’ is used to refer to drugs within these three categories.

The Misuse of Drugs Regulations 2001 permit the use of controlled drugs in healthcare and further classify controlled drugs in to one of five Schedules that reflect the differing levels of control required for use of each category of drug. Controlled drugs are also subject to specific regulations pertaining to the storage and documentation required for their use.

A physiotherapist who is annotated on the HPC register as a Supplementary Prescriber may prescribe controlled drugs under a written Clinical Management Plan. Further changes to Home Office Regulations will be required for Physiotherapists to independently prescribe controlled drugs.

**Types of physiotherapist prescribing**

Appropriately qualified physiotherapists who are registered with the Health Professions Council may apply to have their HPC entry annotated to describe their status as a prescriber. For the foreseeable future the HPC will annotate the SP and IP qualifications separately.
Some physiotherapists will be qualified as both independent and supplementary prescribers, and so will be annotated as SP and IP. Physiotherapists who are only qualified as supplementary prescribers will be annotated as SP only. A supplementary prescriber can only prescribe under a Clinical Management Plan, they cannot prescribe independently.

Standards for prescribing

The HPC define the standards of proficiency that will be required by physiotherapists who wish to use Supplementary and/or Independent Prescribing. The HPC already produce standards for Supplementary Prescribing and will publish the standards required for Independent Prescribing at the time such rights are approved.

The standards will include the proficiencies required to prescribe safely and effectively. These proficiencies are in addition to the proficiencies that apply to non-prescribing physiotherapy practise.

The scope of physiotherapy prescribing

The purpose of physiotherapist-prescribing is to support and enhance the delivery of physiotherapy to patients. As such, physiotherapists will use prescribing either to support and enhance the delivery of other physiotherapeutic interventions that are aimed at addressing health and well-being needs of individuals and groups related to movement, physical performance and human functioning in their widest sense, or to support the delivery of care pathways that can be effectively delivered by a physiotherapist.

Physiotherapist prescribers should not be asked to prescribe for patients to make up for short-falls in other professional prescribing groups.

Physiotherapists are not permitted to prescribe medicines for animals.
Scope of Practice

The education and training programme in prescribing ensures physiotherapists are equipped with the principles of prescribing to enable them to be safe, effective and cost-effective prescribers. Physiotherapist prescribers should ensure that they are able to apply the prescribing principles to their own area of practice, bearing in mind that this may be a requirement for continuing registration. Physiotherapist prescribers must only prescribe within their scope of practice and understand that if they change clinical areas they will require a period of training before they are competent to prescribe in a new area of practice.

An individual’s scope of physiotherapy practice must fall within the overall scope of the profession, therefore an individual’s physiotherapy-prescribing practice must fall within the overall prescribing scope of the profession.

At the current time, prescribing is not permitted by physiotherapists outside of the UK and therefore a physiotherapist permitted to independently prescribe in the UK cannot perform this activity outside of UK jurisdiction.

Prescribers must have sufficient education, training and competence to:

- Assess a patient’s clinical condition
- Undertake a thorough history, including medical history and medication history (including over-the-counter medicines and complementary therapies),
- Diagnose where necessary
- Decide on management of the presenting condition and whether or not to prescribe and/or refer.
- Identify appropriate products of medication as required
- Advise the patient on risks, benefit and outcomes of the medication
- Prescribe if the patient agrees
- Monitor the patient’s condition, including any response to the medication prescribed
- Give lifestyle advice as appropriate
- Refer to other professionals if necessary
This Guidance underpins the principles of prescribing practice within the context of the full scope of physiotherapy practice. The Allied Health Professions Competency Framework published by the National Prescribing Centre (www.npc.co.uk/publications/ahps/htm) provides further prescribing information grouped into the following domains:

- Clinical and pharmaceutical knowledge
- Establishing options
- Communicating with patients
- Prescribing safely
- Prescribing professionally
- Improving prescribing practice
- Information in context
- The NHS in context
- The team and individual context

Registration and Professional Liability Insurance (PLI)

Physiotherapists who are members of the Chartered Society of Physiotherapy (CSP) benefit from personal Professional Liability Insurance (PLI) as part of their membership of the CSP. In order for their PLI to be in force (subject to the terms of the policy), the CSP member must:

- Hold current registration with the HPC
- Hold a current CSP membership in a category that provides PLI cover at the time that treatment of advice is given
- Be practising lawfully
- Be practising within the overall scope of the profession of physiotherapy

Prescribing is accepted as within the overall scope of the physiotherapy profession and due to the requirement for a physiotherapist to be practising lawfully for PLI to be in force, for prescribing to be covered as part of an individual’s PLI the member must

- Have an HPC annotation showing their prescribing status as either an independent and/or supplementary prescriber
CSP members do not need to inform the CSP of their prescribing status, but they must not prescribe until they are satisfied that their HPC entry has been updated.

Physiotherapists who are not members of the CSP will need to ensure they have adequate insurance in place for their practice. They may be personally liable for any costs if they are not adequately or appropriately insured.

All physiotherapists who are employed should be covered by their employer under Vicarious Liability for civil wrongs committed by the employee in the course of their employment. All physiotherapists who are employed should also be covered by Employers’ Liability if they injure a colleague at work. Employers should have insurance in place to cover their ‘vicarious’ and ‘employer’ liabilities.

Many employers now expect individual health professionals to hold their own personal insurance in addition to any employer vicarious liability insurance that may be in force. Physiotherapists who wish to join the CSP in order to gain PLI and a variety of other benefits and professional support are very welcome and should contact www.csp.org.uk
SECTION 1 – PRINCIPLES OF GOOD PRESCRIBING PRACTICE

This section provides advice and guidance on prescribing practice. Having achieved the competencies for prescribing, physiotherapists are expected to follow this advice in their practice.

The advice and guidance provided in this document applies to all settings in which a physiotherapist may prescribe – within the NHS, private practice, prison service, armed forces, sporting settings or any other health and social care sector.

The CSP considers it good practice, that where physiotherapists are employed, that the employing organisation signs off all protocols and procedures. Where possible physiotherapist prescribers should follow organisational-level policies and procedures and should only create local department level procedure where no organisational policy or procedure is in existence.

PRACTICE GUIDANCE 1: LICENCE TO PRESCRIBE

1.1 You must only prescribe once you have successfully completed an HPC approved prescribing programme, and had your entry on the register of the Health Professions Council annotated to show your prescribing status as a supplementary and/or independent prescriber.

1.2 You should comply with this Practice Guidance, other guidance issued by the CSP, and with any statutory requirements applicable to your prescribing practice. Failure to do so may put your HPC registration at risk if concerns are raised about your fitness to practise.

1.3 You must only prescribe within your own defined scope of practice and clinical specialty.

1.4 You may prescribe any licensed medicine. You may prescribe controlled drugs as a Supplementary Prescriber if the drugs are listed within a written Clinical Management Plan. You may prescribe unlicensed medicines only when acting as a Supplementary Prescriber acting within a written Clinical Management Plan.

1.5 You must understand which legal framework you are using to supply and administer and/or prescribe medicines, and ensure that those to whom you delegate aspects of supply/administration are aware of which framework your instruction is given under.
PRACTICE GUIDANCE 2: ACCOUNTABILITY

2.1 You are professionally accountable for your own prescribing decisions, including actions and omissions. You cannot delegate this accountability to any other person nor can any other person accept accountability on your behalf for your actions. As an independent prescriber you are wholly responsible for all aspects of the prescribing process. As a supplementary prescriber you are wholly responsible for your decision to prescribe or use the medicines listed within the written CMP. The decision to include medicines in a CMP may be shared between you and the medical prescriber.

2.2 You must only prescribe within your level of education, training and competence, acting in accordance with the HPC’s Standards of Proficiency, the CSP’s Rules of Professional Conduct and Standards of Physiotherapy Practice.

2.3 If you move to another area of practice you must consider the requirements of your new role and only prescribe within your level of education, training and competence for that new speciality. You may need to undertake further training in order to establish your competency to prescribe in your new clinical specialty.

2.4 You must inform anyone who needs to know about any limitations to your prescribing practice. In particular, other practitioners with dispensing responsibilities need to know about this. For example, your employer may operate a specific prescribing formulary and may not allow you to prescribe outside of this formulary. This restricted formulary would only apply to your NHS practice for that employer.

2.5 You must also inform the relevant authorities if you have any formal regulatory restrictions placed on your prescribing activity, for example, if the HPC forbids you to prescribe controlled drugs.

PRACTICE GUIDANCE 3: ASSESSMENT

3.1 In order to prescribe for a patient you must satisfy yourself that you have undertaken a full assessment of the patient, including a thorough history and, where possible, accessing a full clinical record including medication history.

3.2 You must prescribe only where you have relevant knowledge of the patient’s health and medical history commensurate with the prescribing decisions you are taking.

3.3 You must ensure you have considered the patient’s current medication and any potential interactions with other medicines.
3.4 You should take steps to ensure that the patient is not suffering from any medical condition, or receiving any other treatment, that would make the prescription of any medicine unsuitable or dangerous.

3.5 You should ensure you consider the effects of your patient’s lifestyle which may affect the safety of the medicines you prescribe. This will include:
   - The effects of smoking, caffeine, alcohol
   - The effects of ‘recreational’ or ‘street’ drugs or those used to enhance physical or sporting performance
   - The effects of over-the-counter medicines including herbal preparations

3.6 Where necessary you should have the ability to request and/or have access to the results of additional appropriate tests. These tests should be relevant to the presenting condition and/or appropriate to the prescribing decisions to be made in order to assist your prescribing decisions. These may include:
   - Blood haematology
   - Blood biochemistry tests e.g. liver, thyroid and/or kidney function
   - Radiological investigations

3.7 You may be asked to assess and prescribe in out-of-hours or on-call settings. Physiotherapists must refer to another appropriate prescriber if they do not fully understand the implications of their prescribing actions even though they may be able to take a thorough and appropriate history which leads to a diagnosis. You must only prescribe for patients who are part of your own caseload or under your care. You must not write up prescriptions for patients simply because you are the only prescriber available.

PRACTICE GUIDANCE 4: CLINICAL NEED

4.1 You must only prescribe where you have assessed the patient and there is a genuine clinical need for the prescription of medicines.

4.2 You must also consider the circumstances in which you may decide to withdraw medication, cease to continue prescribing a named medication or alter the prescribed dose of a medication. Patients may also wish to discuss with you withdrawal from medication at their choice. Any withdrawal from medicines needs to be planned in partnership with the patient and take place over an agreed time period.

4.3 You should never prescribe for your own convenience, or simply because a patient demands that you do.

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iii If you are on-call, the patients ‘under your care’ are the patient population for whom you are on-call for, for the duration of your on-call period.
4.4 You should prescribe in the patient’s best interests and achieve this by reaching agreement with the patient on the use of any proposed medicine where possible. The amount of information you discuss with your patient will vary according to the nature of the patient’s condition, the risks and benefits of the medicine and any alternatives, and the patient’s wishes, but in all circumstances will include the provision of ‘sufficient information’ to allow the patient to make an informed choice i.e. to give their informed consent. You should aim to:
  o Establish the patient’s priorities, preferences and concerns
  o Discuss alternative treatment options available to the patient
  o Satisfy yourself that you have enough relevant information to make a prescribing decision
  o Satisfy yourself that the patient understands how to take the medicine as prescribed

4.5 You must only prescribe for patients who are part of your own caseloadiv or under your own care. You must not write up prescriptions for patients simply because you are the only prescriber around.

PRACTICE GUIDANCE 5: CONSENT

5.1 You must explain your role as a non-medical prescriber to the patient or their representative. You must provide your patient with ‘sufficient information’ relating to the risks, benefits and significant and material outcomes of the medicines management you are considering as well as the comparative risks of alternative treatment options to medication that may be considered.v The provision of ‘sufficient information’ is required to ensure the patient is able to make a decision appropriate for them and thus give ‘informed consent’ to treatment.

5.2 You must be aware of the variety of social, cultural and religious factors that may impact upon the choices your patient makes in agreeing prescribing decisions with you.

5.3 You must act in accordance with Department of Health, CSP and employer guidance on the obtaining and documenting of consent.

5.4 You must make it clear to the patient that prescribing activity cannot be undertaken in isolation. You should inform anyone else who may be in a position to prescribe for that patient of your actions to avoid prescribing errors. This is most likely to be the patient’s general medical practitioner, but may also include other health and social care professionals. If the patient refuses to consent to you sharing such information you must offer an explanation of the risks of not doing so. If the patient continues to refuse to give

iv See footnote 3 above
v Bolam v Friern HMC [1957] 2 All ER 118; Sidaway v Bethlem RHG [1985] 1 All ER 653; Chester v Afshar [2004] UKHL 41; Birch v University College London Hospital [2008] EWHC 2237 (QB).
consent, you must consider which course of action, including not to prescribe, would be in the best interests of the patient. This must be documented in their records.

5.5 You must clearly explain to a patient if you will be prescribing unlicensed medicines or using a medicine in a way not specified within the Summary of Product Characteristics. The patient has the right to refuse to accept any medication you may prescribe for them, but if they do so you should explain the risks, benefits and outcomes of their decision.

5.6 The patient should be provided with any relevant Patient Information Leaflet (PIL) about the medicine you propose to prescribe, if appropriate, in order to assist them in making an appropriate decision. In in-patient settings where a PIL may not be routinely supplied, patients can request such information if they wish and should be supplied with the information they require.

5.7 The patient must be clearly informed if the medicine being prescribed is part of a properly conducted clinical research trial and to consider whether they wish to be part of that trial.

PRACTICE GUIDANCE 6: COMMUNICATION

6.1 You must communicate, using the most appropriate media, effectively with other practitioners involved in the care of the patient. This includes communication across NHS-private practice boundaries where necessary. You must refer the patient to another prescriber when it is necessary to do so.

6.2 Prescribing decisions should be made in partnership with the patient, where practicable to do so. This will include taking into account the patient’s personal views and beliefs and discussing prescribing and medication decisions in relation to these.

6.3 Prescribing is not an activity that occurs in isolation. Prescribing information must be shared with other health professionals who need to know the information for the benefit of the patient and this will include the patient’s GP. You should decide the best methods of sharing this information. Where possible, you should have access to other professionals’ prescribing decisions where they impact upon your own decisions. This will include communication across NHS-private practice boundaries where it is necessary to ensure that clinicians have appropriate information to inform their prescribing practice.

6.4 You must know what medication the patient is currently taking including Over-The-Counter and herbal preparations before prescribing new medications and you must take steps to ensure you have access to the primary source of prescribing information, which is likely to be the GP record.

6.5 Documentation of your prescribing communications should be recorded as described in Practice Guidance 7.
PRACTICE GUIDANCE 7: RECORD KEEPING

7.1 This practice guidance relates specifically to the record keeping of your prescribing actions. You should refer to other standards and guidance for information relating to clinical record keeping in general.

7.2 Prescribing activity (e.g. writing an FP10, using a hospital based treatment/drug card or using an electronic prescribing application, or a private prescription) must occur at the time of contact with the patient in order to ensure contemporaneous activity is captured in the clinical record.

7.3 Documentation of the prescribing activity should be recorded in clinical records at the time of treatment of the patient. It is not good practice to document prescribing activity after the event e.g. at the end of the clinic session or the end of the day. Only in exceptional circumstances should documentation be delayed, but in any event the delay should not exceed 24 hours.

7.4 In supplementary prescribing, the doctor/dentist and supplementary prescribers must share access to, consult and, wherever possible, use the same common patient record.

7.5 Records should include the prescription details, together with relevant details of the consultation with the patient.

7.6 Your records should show that you have communicated with the primary healthcare record keeper (usually the GP) especially with regard to repeat, ongoing or withdrawn prescriptions. For hospital in-patients this may be in the form of the hospital discharge letter and/or clinic letter.

PRACTICE GUIDANCE 8: EVIDENCE BASED PRESCRIBING/PRESCRIBING IN THE PATIENT’S BEST INTERESTS

8.1 You should ensure that your prescribing practice is appropriate, responsible and in the patient’s best interests. Every medicine that is prescribable will have an evidence base recommending its use and you should be aware of the current evidence supporting the use of a given medicine.

8.2 You should prescribe according to the available evidence base. Evidence based prescribing involves the application of the best available evidence when making prescribing decisions. Reference to the evidence base can minimize the risk of adverse drug reactions and ensure the most appropriate medicine is chosen for a patient’s needs.
8.3 You should use national sources of evidence as your primary source of evidence-based prescribing. Such sources include
- NICE Guidelines for clinical conditions
- NICE Guidance for the use of treatments/interventions
- Clinical Knowledge Summaries
- Current edition of the BNF and BNF for Children

8.4 Where you can clearly demonstrate that a national source of evidence is not available, then locally agreed practice based evidence or protocols should be followed.

8.5 You may have a role in helping others to keep up to date and you should share your knowledge with others as appropriate. This will ensure that all prescribing is in accordance with the best available evidence and guidelines.

8.6 You must ensure your prescribing is appropriate and responsible by ensuring you
- are familiar with the current national sources of evidence for the medicine
- are familiar with the current national sources of evidence for the condition you are treating which may also include current evidence for which medicine groups should be used, or not used, and a hierarchy of medicines use.
- Have taken an appropriate assessment of the patient
- Have taken into account the patient’s preferences and expressed wishes with regard to medicines use.
- Have prescribed the appropriate dose for your patient’s age and weight.

PRACTICE GUIDANCE 9: DELEGATION

9.1 You may delegate the administration of a medicine that you have prescribed to another healthcare worker or to the patient themselves. You remain accountable for your prescribing decision, and you are also accountable for your decision to delegate the task of administration to someone else including the patient. This includes your assessment that the person is competent to carry out the task and has received sufficient training to carry out your instructions. You are not accountable for the outcome of an action performed by another person.

9.2 You must not delegate the administration of any medicine that is to be supplied under a PGD. Medicines listed within a PGD can only be administered by the registered health professionals named on the PGD.

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vi In in-patient settings within corporate structures it is assumed that suitable governance arrangements will be in place to monitor the competence of staff to whom you delegate administration of medicines, even if you do not know the personal identity of that person. An example of this would be where you write a prescription on a hospital drug chart and the medicine is administered by a succession of nurses during subsequent shifts.
9.3 When delegating the administration of a medicine to someone else you should record in an appropriate record:
- The name (where possible – see footnote 7 below) and profession that you delegated the administration to
- What you have asked them to administer
- How you have asked them to administer it.

9.4 Where this information is not clearly identifiable from your written prescription then the information should be separately recorded in the patient record.

9.5 You must provide direct supervision of any post-registration physiotherapist who is undergoing a period of training in the safe use of medicines or prescribing.

PRACTICE GUIDANCE 10: INFORMATION GIVEN TO PATIENTS ABOUT THEIR MEDICINES

10.1 Patients, or those authorising treatment on behalf of the patient, should be given sufficient information as they require in order for them to make an informed choice with regard to prescribing decisions. You should include:
- Diagnosis giving rise to prescribing need
- Any known serious or common side effects of the proposed medicine
- How the medicine works
- How long to take the medicine for
- How to stop taking the medicine

10.2 Information provided must be appropriate to the patient’s levels of understanding.

10.3 Where practicable you should support information given to your patients in writing.

10.4 You should tell the patient that their medicine will come supplied with a manufacturer Patient Information Leaflet (PIL) which will give them additional information. In in-patient settings where the PIL is not routinely supplied, patient’s can request such information if they wish.

10.5 You must inform the patient if you propose to prescribe or use any medicine that is unlicensed (including the use of ‘mixed’ medicines), where there is little research or other evidence of current practice to support your proposed use of the medicine, or where the use of the medicine is innovative.
PRACTICE GUIDANCE 11: CLINICAL MANAGEMENT PLANS

11.1 If you are prescribing as a Supplementary Prescriber you must prescribe in accordance with a patient’s individual written clinical management plan (CMP). For a CMP to be legally valid, the independent prescriber must only be a doctor or a dentist\(^{vii}\).

11.2 Where standard written CMPs are in place as a starting point, you must tailor them to reflect the individual patient’s personal, medical and medicines history. The CMP must be agreed with you by a medical prescriber, and with the consent of the patient, before supplementary prescribing begins. This could be in the form of a signature, or for an electronic record, a recordable indication of agreement.

11.3 The supplementary prescriber and independent prescriber may agree to modify a CMP in the light of a patient’s changing needs, and may also decide to terminate the use of a CMP if it is no longer appropriate. The supplementary prescriber should always refer back to the independent prescriber if the patient’s condition changes such that the current CMP is no longer appropriate.

11.4 Within supplementary prescribing you must never prescribe medication in the absence of a written clinical management plan which has been agreed with the independent prescriber and with the consent of the patient. The independent prescriber may agree verbally to a CMP providing that it is confirmed by fax or secure email in writing before prescribing occurs, and is formally recorded within two working days.

11.5 The prescribing of a Prescription Only Medicine (POM) by a supplementary prescriber outside a clinical management plan constitutes a criminal offence under the terms of the Prescription Only Medicines Order. Such action could be subject to prosecution under the Medicines Act (1968), or action by the Health Professions Council under its Fitness to Practise procedures.

11.6 If a physiotherapist who is both an independent and supplementary prescriber sees a patient as a supplementary prescriber, they must adhere to the terms of the CMP when managing the patient’s condition for which the CMP has been agreed. This does not preclude the physiotherapist from prescribing medication for the patient for an unrelated condition, where the physiotherapist is acting as an independent prescriber and is competent to treat the condition concerned. The patient should be told of the distinction between the authority to prescribe as a non-medical independent prescriber, and that of a supplementary prescriber. It should be explained that the physiotherapist is acting as an non-medical independent prescriber in that instance.

\(^{vii}\) The Medicines (Exemptions and Misc Amendments) Order 2009 SI 2009/3062
PRACTICE GUIDANCE 12: TRANSCRIBING

12.1 In some circumstances you may be asked to transfer medicines information from one document to another, a process known as transcribing. Transcribing should not be a routine or regular occurrence.

12.2 If you transcribe, you are accountable for your actions and omissions and this will include any errors you make in transferring the information from one document to another.

12.3 You should satisfy yourself that transcribing is a necessary activity that cannot be eliminated by reviewing and improving the care pathway. If transcribing must occur, you should ensure that the activity meets local clinical governance requirements.

12.4 Any transcription must include
- Patient’s full name
- Date of birth
- Name of medicine
- Drug dosage, strength, timing, frequency and route of administration.

PRACTICE GUIDANCE 13: ELECTRONIC PRESCRIBING

13.1 If you prescribe using e-Prescribing software you must also be using a compatible electronic clinical record software package that allows your prescribing activities to be referenced and cross-checked against the main electronic clinical record. The purpose of electronic prescribing is to reduce medicines errors and reduce patient morbidity and mortality; therefore the prescribing record must be linked to the clinical record.

13.2 You may prescribe via computer-generated prescriptions providing the necessary software is available.

13.3 A traceable audit trail of your prescribing actions must be maintained.

13.4 You must never print off blank prescriptions in advance and then store them for future use.

PRACTICE GUIDANCE 14: WRITING NHS PRESCRIPTIONS

14.1 In order to write an NHS prescription, the medicine must be permitted to be prescribed at NHS expense. You should check the BNF if you are not sure if a medicine is available on the NHS. If a medicine is not available at NHS expense, it can only be prescribed against a private prescription (see Practice Guidance 15).
14.2 Your written prescription must contain the information required by law such as:
- It must be signed in ink
- It must contain your name and workplace address
- The date on which the prescription was signed by you and/or the date after which it can be dispensed
- Your profession
- The name and address of the patient
- The age of the patient if they are under 12 years old

14.3 The names of the medicines must be written clearly using approved names only. You must not use abbreviations in the name of the medicine.

14.4 A non-repeat prescription is valid for six months after the date of signing, however you should ensure that the medicines prescribed are appropriate for the patient’s needs as you have assessed them, therefore the reasons for any significant delay between assessment and prescription dispensing should be documented.

14.5 You must only write prescriptions for your NHS patients on an in-patient drug chart, an in-patient hospital discharge and/or clinic letter, an in-patient TTO form, or an FP10 for outpatients. You must only use the FP10’s that have been issued specifically to you for your NHS practice and that show your name and HPC registration number on them. All the details listed in section 14.2 must be included.

14.6 You must never tamper with an existing prescriber’s details on a prescription form or add your own prescribing details.

14.7 You must sign your prescriptions immediately after they are produced. If this is not possible (e.g. the prescription is printed in a dispensary away from your clinic room), the unsigned prescriptions must be securely stored until you can sign them. You must sign them within 24 hours.

14.8 You must never sign a blank prescription form in advance and then store them for future use.

14.9 If you are prescribing Controlled Drugs (subject to Schedule 2 or 3 of the Misuse of Drugs Act) this must be in accordance with current provisions.

PRACTICE GUIDANCE 15: WRITING PRIVATE PRESCRIPTIONS

15.1 You may write a private prescription for a patient who is receiving non-NHS care. Private prescriptions can be written for medicines that are not available on the NHS. You must not use an NHS prescription form to prescribe medicines privately. A private prescription cannot be used for NHS funded care.
15.2 A private prescription may be written on any document and it must contain the following:

- It must be signed in ink
- It must contain your name and workplace address
- The date on which the prescription was signed by you and/or the date after which it can be dispensed
- Your profession
- The name and address of the patient
- The age of the patient if they are under 12 years old

15.3 The names of the medicines must be written clearly using approved names only. You must not use abbreviations in the name of the medicine.

15.4 NHS prescription forms (FP10’s) must not be used to meet the medicines needs of patients whose healthcare is being provided by the non-NHS sector. Patients receiving medicines as part of private healthcare provision are liable for the actual costs of the medicines and any private prescription charge. You must not ask the patient’s GP to prescribe medicines at NHS expense which are subsequently to be administered as part of private healthcare provision. If you do ask a GP to do this, they are within their rights to refuse to do this. A GP may, in some circumstances, agree to write a private prescription for their patient.

PRACTICE GUIDANCE 16: REVIEWING PRESCRIPTIONS

16.1 You should review a patient’s medication regularly and in particular when you are starting a new medication, stopping a medication or changing a dose of a current medication.

PRACTICE GUIDANCE 17: REPEAT PRESCRIPTIONS

17.1 Repeat prescriptions are valid for six months and, unless specified in writing on the prescription otherwise, the medicine may be dispensed twice within the validity of the prescription (with the exception of contraceptives which may be dispensed six times). You should ensure that you review your patient’s medication at regular intervals to ensure the prescription remains appropriate for your patient’s needs.

17.2 If you issue repeat prescriptions you must ensure that you prescribe safely and responsibly. Before signing repeat prescriptions you must be satisfied that it is safe and appropriate to do so. You should review repeat prescriptions regularly and do not issue medicines for longer than is clinically required. You should ensure the correct dose is prescribed for medicines where the dose varies according to the stage of the treatment.
SECTION 2 – SPECIAL PRESCRIBING CIRCUMSTANCES

PRACTICE GUIDANCE 18: FAMILY, FRIENDS AND CLOSE COLLEAGUES.

18.1 You must not prescribe medications to treat yourself. You should be registered with your own medical and/or health practitioner who will be objective in providing you with good care.

18.2 You should wherever possible avoid prescribing for those close to you. People close to you may include your immediate family (parents, grandparents, children, grandchildren, siblings, aunts, uncles and first cousins), someone with whom you have an intimate personal relationship, your friends, and may also include colleagues with whom you regularly work. People you prescribe for should be formally on your caseload as your patient. If you are employed you must check your employer’s policy on whether you are permitted to treat family, friends and colleagues.

18.3 You should avoid prescribing for family, friends and colleagues unless:
- No other prescriber is available to assess their clinical condition and to delay prescribing would put their life or health at risk, or cause intolerable pain
- The treatment is immediately necessary to:
  - Save life
  - Avoid serious deterioration in their health and well-being
  - Alleviate otherwise uncontrollable pain.

18.4 You must not prescribe a controlled drug for someone close to you unless
  - No other prescriber is available to assess the patient’s clinical condition and to delay prescribing would put the patient’s life or health at risk, or cause intolerable pain

18.5 You must be able to justify your decisions to prescribe for those close to you. You must record the nature of your relationship and the special circumstances that necessitated your action of prescribing for family and friends.

PRACTICE GUIDANCE 19: CHILDREN

19.1 Medicines are potent treatments and prescribing them can present significant risk to patients. This is especially so for children, whose responses may differ from adults. It is essential that registrants recognise the unique implications of prescribing for children and young people. Caution should also be taken when prescribing for pregnant and lactating women.
19.2 Only physiotherapists with relevant education, training and competence in treating children should prescribe for children. Anyone prescribing for a child must be able to demonstrate competence to prescribe for children and to refer to another practitioner when working outside their area of expertise and level of competence.

19.3 In all cases reference should be made to the following documents that address medicines management issues in paediatrics:
- The BNF for Children (England/Wales/Scotland) at www.bnfc.org
- Medicines Standard: National Service Framework for Children, Young People and Maternity Services (Wales)
- Royal College of Paediatrics and Child Health – information on use of licensed and unlicensed medicines at www.rcpch.ac.uk/publications
- Scottish Executive - The Administration of Medicines in Schools and The Right Medicine: A Strategy for Pharmaceutical Care in Scotland
- SIGN Guidance at www.sign.ac.uk
- DHSSPS – Medicines Management Standard

PRACTICE GUIDANCE 20: UNLICENSED MEDICINES

20.1 Medicines may be classed as unlicensed either as original products, or by virtue of their preparation e.g. mixing two licensed medicines together which creates a new unlicensed product. An unlicensed medicine does not hold a UK Marketing Authorisation issued by the MHRA.

20.2 A Supplementary Prescriber may prescribe unlicensed medicines within a written CMP, but if you decide to do so you must:
- Be satisfied that an alternative, licensed product would not meet the patient’s needs
- Be satisfied that there is a sufficient evidence base of using the unlicensed medicine to demonstrate safety and efficacy
- Record the medicine prescribed and the reasons for using an unlicensed product in the patients notes
- You must clearly explain to a patient if you will be prescribing unlicensed medicines or using a medicine in a way not specified within the Summary of Product Characteristics. The patient has the right to refuse to accept any medication you may prescribe for them, but if they do so you should explain the risks, benefits and outcomes of their decision.

20.3 Further law change is required before a physiotherapist Independent Prescriber can prescribe unlicensed medicines.
PRACTICE GUIDANCE 21: OFF-LABEL USE OF MEDICINES

21.1 An off-label medicine does hold a UK Marketing Authorisation issued by the MHRA, but is being used in a way that is not described within the medicine’s Summary of Product Characteristics.

21.2 Independent and/or Supplementary Prescribers may prescribe medicines for off-label use, but if you decide to do so you must:
- Be satisfied that a licensed medicine is not available which includes your proposed usage within its SPC
- Be satisfied that there is a sufficient evidence base for using the medicine in an off-label way to demonstrate safety and efficacy. Where the manufacturer’s information is of limited help, the necessary information should be sought from another reliable and reputable source
- Record the medicine prescribed and the reasons for using an off-label product in the patient’s notes
- You should explain to a patient in broad terms why you are using the medicine in an off-label way
- You should make a clear, accurate and legible record of your reasons for using a medicine in an off-label manner

21.3 Pharmaceutical companies do not usually test their medicines on children and consequently cannot apply their Marketing Authorisations for their products to use in children. It is often necessary in paediatric practice to use licensed medicines in off-label ways. You must consult the BNF for Children before prescribing for children.

PRACTICE GUIDANCE 22: REMOTE PRESCRIBING

22.1 Most prescribing should occur on the basis of a face-to-face consultation with the patient. Remote prescribing occurs if you issue a prescription based on a telephone, e-mail, fax, video-link, web-based or other non face-to-face contact with a patient.

22.2 You should only remote-prescribe for your own patients or patients on your own case-load. You must ensure that you have an appropriate dialogue with your patient to:
- Establish the patient’s current medication history
- Carry out an adequate assessment of the patient’s condition
- Ensure there is sufficient justification to prescribe the medicines remotely, including discussing the feasibility of seeing another prescriber who can carry out a face-to-face consultation. This is particularly important when a remote-consultation does not permit an adequate assessment of the patient’s condition to be undertaken
- Ensure there are no contraindications to the proposed medicine
- Ensure arrangements are in place to provide follow-up and continuity of care
Ensure a clear record is made of the prescribing decision and in particular the method of remote prescribing used e.g. instruction over the phone, e-mail etc.
Ensure that the primary care record holder is informed
Ensure that the patient has ‘sufficient information’ to make an informed choice to accept your recommendation

22.3 Where you cannot satisfy all of the conditions above, you should not use remote means to prescribe for your patient.

22.4 Where a medication has not been prescribed before, you should not prescribe remotely if you have not assessed the patient, except in life-threatening situations.

PRACTICE GUIDANCE 23: USE OF PATIENT’S OWN MEDICINAL PRODUCTS

23.1 Patients may have their own supply of medicines that they seek your advice on. These medicines may
  • Have been prescribed by another prescriber,
  • Have been bought over the counter
  • Be herbal or homeopathic preparations that may, or may not, be subject to MHRA registration
  • Be complementary products

23.2 Such products are the patient’s own property and must not be removed without the patient’s permission.

23.3 You may ask to see such products, or the patient may ask you about their suitability for continued use. Provided you are educated, trained and competent to do so you may:
  • Check that the products are suitable for the patient to use and if they are not you should advise the patient of this
  • Explain how the medicine should be taken, including explaining any direction given by another prescriber in the case of prescribed medicines. If the patient is not taking the medicine as directed, you should advise of any changes needed to achieve this
  • Give advice on dose alteration, including stopping medication. If this relates to a POM product prescribed by another professional you must have access to the primary medical record in order to record the change you have made to a prescribed medicine.
  • Advise a patient that a given product may not be suitable for the patient’s needs or may cause an interaction with other products that may cause unexpected effects for the patient
PRACTICE GUIDANCE 24: WORKING AND/OR TRAVELLING WITH SPORTS TEAMS

A: Supply and Administration Issues:

24.1 Instructions to supply and administer medicines must be given in writing and a record kept. An oral instruction is not acceptable on its own as there will be no independently verifiable record of what was said. In certain exceptional circumstances, it will be necessary to act on an oral instruction. A physiotherapist acting on an oral instruction must record what the circumstance was that prevented a written instruction being given and must record exactly what the instruction was and who gave it.

24.2 Remote instruction occurs if you receive an instruction based on a telephone call, e-mail, fax, text-message, video-link, web-based or other non face-to-face contact with the prescriber.

24.3 Written remote-instructions (e-mail, fax) must be printed off and collated with the patient’s clinical record. This should be followed up with an appropriate written prescription signed by the prescriber.

24.4 Non-written remote prescriptions such as text-messaging may become increasingly common. If you supply and administer on the basis of a text message from a prescriber you should obtain a second signatory to your clinical record to confirm that your record of the prescription agrees with the text message. The text message should be regarded as patient-confidential information and should be deleted from the receiving handset after transcription to, and countersigning of, the clinical record.

24.5 Local polices must be in place to ensure that use of web-based and/or portable products for communication are secure and provide a robust audit trail. Clinical governance procedures should be in place to support such practice.

B: Prescribing Issues:

24.6 The introduction of independent prescribing by physiotherapists will apply across the UK as is already the case for supplementary prescribing. The devolved administrations in Scotland, Wales and Northern Ireland will decide how they implement prescribing by physiotherapists in their respective National Health Services and this will require separate legislation. Non-medical Supplementary and Independent prescribing on a private basis will be legal in all four countries. Prescribing for sports teams constitutes private prescribing.

24.7 A supplementary prescriber may prescribe in accordance with a written CMP for the benefit of their patient. All athletes within a sporting team / governing body structure could
therefore have a CMP in place to facilitate their access to medicines for their benefit even when a doctor is not present with them. This would require all physiotherapists who wished to use such patient-specific CMPs to be Supplementary Prescribers.

24.8 Independent and/or Supplementary prescribing is not lawful outside of the United Kingdom and so cannot be used when a Supplementary and/or Independent Prescriber physiotherapist is subject to any jurisdiction other than UK law e.g. when working abroad.

PRACTICE GUIDANCE 25: CONTROLLED DRUGS

25.1 Controlled drugs may be prescribed by a Supplementary prescriber working within a written Clinical Management Plan (CMP). Further changes to Home Office Regulations will be required to permit physiotherapist Independent Prescribers to prescribe controlled drugs from a limited list.

25.2 Physiotherapists are most likely to use controlled drugs in settings and circumstances where patients are cared for as part of a medical Consultant-led team and where the physiotherapist has regular and on-going access to the Consultant. Examples include A&E and in-patient hospital settings for management of acute and pre/post-operative pain, palliative care and end-of-life care; out-patient hospital settings for chronic pain management\(^\text{viii}\); hospice care for palliative and end-of-life care. In professional sport, there may be occasional rare circumstances when a physiotherapist may need to administer controlled drugs for the immediate pain relief associated with broken limbs sustained during contact sports.

It is not anticipated that single-handed physiotherapists would have a justified need to prescribe controlled drugs.

25.3 You must not prescribe a controlled drug for yourself.

25.3 You must not prescribe controlled drugs for someone close to you unless
- No other prescriber is available to assess the patient’s clinical condition and to delay prescribing would put the patient’s life or health at risk, or cause intolerable pain.
- You must be able to justify your decisions to prescribe controlled drugs for those close to you. You must record the nature of your relationship and the special circumstances that necessitated your action of prescribing controlled drugs to those close to you.

25.4 You may use computer-generated prescriptions for controlled drugs, providing the necessary software is in place and that there is an audit trail of your prescribing practice.

\(^\text{viii}\) In these settings the GP may be asked to provide the controlled drug on the recommendation of the secondary care team.
25.5 An example FP10 prescription for controlled drugs is included within the BNF. You must ensure you have the most current version of the controlled drugs prescription form.

25.6 The legal requirements for prescribing Schedule 2 and 3 controlled drugs are summarised in the BNF. You should also ensure the recommendations from the 4th Report of the Shipman Inquiry are followed:
- Prescriptions for controlled drugs are uniquely marked to identify them as controlled drug prescriptions
- Private prescription forms for controlled drugs are similar to NHS controlled drug prescription forms
- The registration number of the prescriber must be included on controlled drug prescriptions
- The patient’s NHS number, or other unique identifier, will be included on the controlled drug prescription form
- All controlled drug prescriptions, except Schedule 5, will be valid for 28 days only.

25.7 Standard Operating Procedures should be in place for the use of Controlled Drugs (CDs) and should include procedures for:
- Ordering and receipt of CDs
- Assigning responsibilities
- Where the CDs are to be stored
- Who has access to CDs
- Security in the storage and transportation of CDs as required by Misuse of Drugs legislation
- Disposal and destruction of CDs
- Who is to be alerted if complications arise
- Record keeping, including:
  - Maintaining relevant CD registers under Misuse of Drugs legislation
  - Maintaining a record of the CDs specified in Schedule 2 to the Misuse of Drugs Regulations 2001 that have been returned by patients

The Standard Operating procedures should also include:
- Responsibilities within the multidisciplinary team
- Validation by the healthcare organisation and date
- Review period, e.g. one, two or three years
- Lead author and named people contributing to the Standard Operating Procedure
PRACTICE GUIDANCE 26: MIXING OF MEDICINES PRIOR TO ADMINISTRATION

26.1 Under the terms of the Medicines Act, when two medicinal products are mixed together prior to administration and one cannot be described as a vehicle for the other, this meets the definition of “manufacture” and results in the creation of a new, unlicensed product. Combinations of licensed medicines may be used in a wide range of clinical settings, but in each case where two medicinal products are mixed and one cannot be described as a vehicle for the other, there are restrictions on the use of ‘mixed medicines’. The act of ‘mixing’ is not in itself prescribing.

26.2 ‘Mixing’ can occur under a Patient Specific Direction (PSD) or under a written Clinical Management Plan (CMP) within Supplementary Prescribing. Nurse- and Pharmacist-Independent prescribers can ‘mix’ medicines.

26.3 ‘Mixing’ cannot occur within a Patient Group Direction (PGD). Further changes to legislation need to occur to enable a physiotherapist Independent Prescriber to ‘mix’ medicines.

26.4 Further guidance can be found on the National Prescribing Centre www.npc.co.uk and the CSP publication PD003 (July 2010) www.csp.org.uk

PRACTICE GUIDANCE 27: PRESCRIBING ON THE RECOMMENDATION AND/OR AT THE REQUEST OF OTHERS

27.1 You should only prescribe for patients on your own caseload/under your overall care. You cannot prescribe for any patients upon whom you have not undertaken an appropriate assessment. You must not prescribe for a patient unknown to you simply because you are the only prescriber available except in an absolute emergency where the patient’s life is in imminent danger.

27.2 The requirements for non-medical independent prescribing are not the same as for medical prescribing. If you prescribe on the recommendation of another health professional who does not have prescribing rights, you must satisfy yourself that you have performed an appropriate assessment of the patient yourself in order to reach a diagnosis in order to determine if the prescription request is appropriate for the patient concerned and that the professional is competent to have recommended the medication.

27.3 You do not necessarily have to conduct a face-to-face consultation with the patient but you must ensure an appropriate assessment has taken place in order to gain enough sufficient information upon which to make your prescribing decision. Where you cannot satisfy yourself of this, you should not prescribe on the recommendation of others.
PRACTICE GUIDANCE 28: SIMULTANEOUS PRESCRIBING AND ADMINISTRATION

28.1 Prescribing and/or supply followed by simultaneous administration of medicine to the patient creates the opportunity for errors to occur as there is no formal division between the prescribing and then supply and/or administration functions.

28.2 If you prescribe for a patient you should allow someone else, ideally a Pharmacist, to supply the medicine to the patient wherever possible prior to administration.

28.3 Where prescribing and/or supply occurs simultaneously with administration of medicine to the patient this should only be done where it is in the patient’s best interests for this to occur AND there should also be an additional check by a second person to ensure that what is prescribed is actually what is supplied and/or administered to the patient. The second ‘checker’ need not be a prescriber or registered health-professional themselves but should be able to verify that the correct medicine is being supplied to the patient.

28.4 All physiotherapists using a PGD to supply and administer medicines should consider the need to have a ‘second checker’ to ensure that the patient receives the correct medicine.
SECTION 3 – MEDICINES GOVERNANCE

These medicines governance arrangements apply to all settings. This covers private practice settings, including where part of your home is your private practice, as well as NHS and other hospital, clinic and occupational health settings. The guidance in this section will apply alongside any organisational policies and/or procedures that the organisation may have in place.

PRACTICE GUIDANCE 29: INSTRUCTIONS FOR SUPPLYING AND/OR ADMINISTRATION

29.1 You should check that the direction to supply and/or administer medicines to your patient is appropriate according to your assessment of the patient’s needs. If you have any concerns with regard to the instructions given, you must consult the prescriber before administering the medicine to the patient.

29.2 If you instruct another person to supply and/or administer medicines on your behalf, you must ensure that the individual is educated, trained and competent to do so. Where you believe this not to be the case, you may refuse to instruct another person to supply and administer on your behalf.

29.3 When supporting patients to self-administer medicines, you must ensure that they are able to do so safely and ensure that you have followed any local policy in place relating to supporting patients to take their own medicine.

29.4 Instructions to supply and administer medicines must be given in writing and a record kept. An oral instruction is not acceptable on its own as there will be no independently verifiable record of what was said. In certain exceptional circumstances, it will be necessary to act on an oral instruction. A physiotherapist acting on an oral instruction must record what the circumstance was that prevented a written instruction being given and must record exactly what the instruction was and who gave it.

29.5 Remote instruction occurs if you receive an instruction based on a telephone call, e-mail, fax, text-message, video-link, web-based or other non face-to-face contact with the prescriber.

29.6 Written remote-instructions (e-mail, fax) must be printed off and collated with the patient’s clinical record. This should be followed up with an appropriate written prescription signed by the prescriber.

29.7 Non-written remote prescriptions such as text-messaging may become increasingly common. If you supply and administer on the basis of a text message from a prescriber you
should obtain a second signatory to your clinical record to confirm that your record of the prescription agrees with the text message. The text message should be regarded as patient-confidential information and should be deleted from the receiving handset after transcription to, and countersigning of, the clinical record.

29.8 Local polices must be in place to ensure that the use of web-based and/or portable products for communication are secure and provide a robust audit trail. Clinical governance procedures should be in place to support such practice.

PRACTICE GUIDANCE 30: DISPENSING

30.1 Dispensing is the preparation and supply of a medicine in accordance with the instructions contained within a prescription. Dispensing is generally performed by a Pharmacist or Pharmacy Technician. You must ensure the separation of prescribing and dispensing of medicines whenever possible. You should not normally dispense against a prescription that you have written.

30.2 You should not dispense medicines unless there is a local policy in place, agreed by the Clinical Governance Lead, to endorse your actions.

30.3 If you do dispense, you must understand the medicine you are dispensing, its therapeutic effect, correct dosage, side-effects and contra-indications. You should be able to inform the patient what to expect when taking the medicine and how to report any unexpected effects.

30.4 You should only dispense if you are educated, trained and competent to do so. A record must be kept of your dispensing actions and you should ensure that an audit trail is present and visible.

PRACTICE GUIDANCE 31: STORAGE

31.1 You should ensure all medicinal products are stored in accordance with the information within the Summary of Product Characteristics/Patient Information Leaflet or information found on the label. Some medicines may require refrigerated storage.

31.2 Medicines can only be stored in ‘lockable business premises’ prior to delivery to the patient. When not in use, medicines should be stored in lockable containers or cabinets or otherwise returned to a Pharmacy department for safe-keeping.

31.3 NHS staff: You must not store medicines at home unless you must have the written permission of your employer to do this which describes the exceptional circumstances that require you to store medicines in your home, and you must have suitable lockable storage facilities in place.
Home-based Private practice: You must only store medicines in lockable containers that constitute 'lockable business premises' which are within the business part of your premises.

31.4 All storage environments must meet the prevailing storage requirements and it is your responsibility to find out what these requirements are. You must ensure correct storage policies are in place and are being adhered to.

PRACTICE GUIDANCE 32: TRANSPORTATION

32.1 You may transport medicines from the dispensing pharmacy to their place of use. You must display appropriate health and safety information on your vehicle if the medicine requires it e.g. medical gases.

32.2 You should not leave medicines unattended in your vehicle at any time.

PRACTICE GUIDANCE 33: DISPOSAL

33.1 You must dispose of used, partially used and unused medicines in accordance with current legislation and your local employer policy.

33.2 If there is no local employer policy in place, you should return all medicines to a Pharmacist for safe disposal.

PRACTICE GUIDANCE 34: ERROR REPORTING

34.1 If you discover that you have made an error in prescribing you must take immediate action to prevent potential harm to the patient, and you must report the error as soon as possible according to local protocols.

34.2 If you think there is an error in a prescription that has been written and/or dispensed by someone else, you must seek clarification of the prescriber’s wishes before administering the medicine. You should also report the error according to local protocols.
35.1 If a patient experiences an adverse reaction to a medication they have been prescribed, you should record this in the patient notes, notify the prescriber (if you did not prescribe the drug) and notify the MHRA via the Yellow Card Scheme immediately. Yellow cards are found in the back of the British National Formulary and also online at www.yellowcard.gov.uk.

35.2 You may also inform the patient that they can report adverse reactions independently to the Yellow Card Scheme.

35.3 You can also report adverse reactions via the Medicines and Healthcare Products Regulatory Agency (MHRA) website at www.mhra.gov.uk and any untoward incidents can be reported to the National Patient Safety Agency (NPSA).

36.1 A physiotherapist can obtain a stock of medicine ahead of its administration to a patient when the physiotherapist is using a Patient Group Direction (PGD) as the legal framework of medicines use and the named medicine is listed within the PGD. PGDs are not valid in all healthcare settings and in particular are not valid in single-handed ‘high-street’ physiotherapy private practice.

36.2 A physiotherapist can obtain the medicines needed for administration to a named patient against a valid prescription for the named medicine that is dispensed by a Pharmacist.

36.3 [SUBJECT TO ENACTMENT] Physiotherapists can obtain supplies of medicines ahead of administration to a patient when the named specific medicine is included in the list of medicines which can be accessed by physiotherapists under Exemptions in medicines legislation.

37.1 Complementary, herbal and homeopathic products may interact with other medicinal products and/or laboratory tests. You should ensure you obtain, and record, information from the patient as to whether they are using any such products. Where there is evidence
that you should do so, you may need to advise that your patient stops using a complementary, herbal or homeopathic product prior to starting taking a conventional medicinal product or undergoing a medical and/or surgical procedure.

37.2 Some herbal and homeopathic preparations are classed as medicines and are classified as POM, P or GSL depending on their action and route of administration. You can only prescribe and/or supply and administer these products in accordance with an appropriate prescribing and/or supply and administration framework.

37.3 The MHRA regulates other herbal products under the Traditional Herbal Registration ( THR) scheme and other homeopathic products under the National Rules Scheme (NRS). Other products may not be subject to regulation of their quality, safety or efficacy. You should only recommend these products if you have suitable education, training and experience to do so.

37.4 The MHRA holds a list of complementary, herbal and homeopathic products that are known to, or may have, interactions with medicinal products and you must be aware of these before recommending that a patient takes a complementary product in addition to, or as a substitute for, any currently prescribed medicine. Some herbal preparations are prohibited or restricted in their use in humans due to known toxic and/or harmful effects, and you should not recommend these products to your patients.
SECTION 4 – CLINICAL GOVERNANCE

Patient safety is of paramount importance within all aspects of prescribing and medicines management. Physiotherapists must practise within the law, to a high professional standard, and ensure that they strive continuously to improve the quality of care that they offer to patients. Poor professional performance needs to be identified and rectified at an early stage. The guidance in this section will apply alongside any organisational policies and/or procedures that the organisation may have in place.

PRACTICE GUIDANCE 38: GOVERNANCE STRUCTURES

38.1 Employed Physiotherapists will be covered by the appropriate Clinical Governance protocols and procedures of their employer. This will include prescribing analysis and clinical audit. Physiotherapists who are not prescribing within the NHS should ensure that they have appropriate clinical governance procedures in place for the safe use of medicines. Arrangements should be made for:
(a) clear lines of responsibility and accountability for overall quality of clinical care;
(b) development of quality improvement programmes such as clinical audit, supporting evidence-based practice, implementation of clinical standards, monitoring of clinical care, access to appropriate CPD programmes;
(c) management of risk;
(d) procedures to identify and remedy poor performance.

PRACTICE GUIDANCE 39: CLINICAL AUDIT

39.1 Clinical audit is an important part of clinical governance, as it helps physiotherapists to monitor their prescribing activities. If the physiotherapist is both an independent and supplementary prescriber, it is useful to audit both independent and supplementary prescribing activities.
39.2 If you are supplementary prescriber you should ensure that you participate in regular (normally at least annually) meetings with your medical independent prescriber partner.

39.3 You should audit how many of the patients for whom you have prescribed medication have required medical follow-up, and how many have been successfully managed within the physiotherapy pathway.

39.4 You should monitor how patients respond to treatment and how many follow-up visits are taking place. Systems should be put in place to ensure that patients who do not attend ('DNA') for their appointments are followed up (e.g. by telephone, letter, text message or email).

39.5 If you are a supplementary prescriber you should audit your practice to ensure that the patient's CMP is being followed.

39.6 You should ensure that the prescriptions you write are clear and legible. You should audit how many times a pharmacist contacts you to query what was written.

39.7 Patients' experiences of physiotherapists prescribing are an important part of clinical care, and should be regularly sought.

PRACTICE GUIDANCE 40: PRESCRIBING ANALYSIS

40.1 You should ensure that you have information about national guidelines (e.g. NICE guidelines, NSFs), local guidelines, local agreements and formularies to ensure you make the best prescribing decision for your patients.

40.2 If you are prescribing within the NHS, your activity should be included in the reports on the quality of clinical care to local Clinical Governance Committees or their equivalent.
PRACTICE GUIDANCE 41: RISK MANAGEMENT

41.1 You should ensure that you have an appropriate Risk Management programme in place. This should include clinical risk management and patient safety (including the NPSA National Reporting and Learning Scheme), confidentiality, safety of prescription pads and a system for handling errors and complaints.

PRACTICE GUIDANCE 42: CONTINUING PROFESSIONAL DEVELOPMENT

42.1 It is your responsibility to remain up-to-date with appropriate knowledge and skills to enable you to prescribe competently and safely.

42.2 You should ensure that your CPD is in line with your current or future practice, including your role as a prescriber.

42.3 You should record your CPD in a format that easily enable you to demonstrate your fitness to practise as a prescriber.

42.4 You should ensure that you set aside sufficient time to access programmes and resources to meet your CPD needs. This may include Peer Review sessions. You should include reflective learning in your CPD portfolio.

PRACTICE GUIDANCE 43: POOR PERFORMANCE

43.1 Procedures should be put in place for identifying poor prescribing practice. This could be via peer review processes or pharmacist/medical practitioner feedback. The National Clinical Assessment Service (NCAS) publishes several documents relating to performance issues. Although currently the NCAS service is only available for doctors and dentists, the principles are applicable to other healthcare professionals including physiotherapists.

Further information is available at www.ncas.npsa.nhs.uk under ‘Key Publications’ and ‘Toolkit’.
PRACTICE GUIDANCE 44: SAFETY OF NHS PRESCRIPTION PADS

44.1 NHS FP10’s are classed as secure stationery. Each prescription has a serial number, and has specific anti-theft and anti-forgery features. Prescription pads will be ordered by the Trusts via a secure ordering system and supplied to the named professional they relate to.

44.2 You are responsible for the safety of your named prescription pad. You must take all reasonable and responsible steps to prevent its loss or inappropriate use. You should only use one prescription pad at a time.

44.3 You should keep a record of the first and last serial number of the prescriptions in the pads issued to you. If a whole prescription pad is lost or stolen you must report the serial numbers of the missing prescriptions.

44.4 At the end of each working day you should record the serial number of the first remaining prescription in your current pad. If your current pad is lost or stolen after you last used it, the relevant serial number of unused prescriptions must be reported.

44.5 Prescription pads should be stored in locked areas when not in use. You should not store prescription pads away from your place or work. In particular you should not store pads at home or in your vehicle except when travelling between places of work.

44.6 Detailed Guidance can be found in ‘NHS Security Management Service- Security of Prescription Forms Guidance October 2009.

PRACTICE GUIDANCE 45: LINKS WITH PHARMACEUTICAL COMPANIES / CONFLICT OF INTEREST

45.1 If you have a commercial or financial interest in any pharmaceutical product or company then you should ensure that your patients have access to this information where relevant, and you should ensure that your interest does not affect your ability to prescribe in the patient’s best interest alone.

45.2 You must not allow your own, or your employer’s (if applicable) commercial or financial interests in a pharmaceutical company or product influence the way you advise your patients.

45.3 You must declare any conflict of interest in a ‘register of interests’ either within your personal portfolio, or within your employers Hospitality Register which should be produced on request for audit purposes.
PRACTICE GUIDANCE 46: GIFTS AND BENEFITS

46.1 You must make your choice of medicinal product for the patient based solely on clinical suitability and cost effectiveness.

46.2 The advertising and promotion of medicines is strictly regulated by the Medicines (Advertising) Regulations 1994. Personal gifts are forbidden and it is an offence to solicit or accept a gift or inducement to influence your prescribing patterns. Companies may offer hospitality for a professional or scientific meeting, but such hospitality must be reasonable in level, and subordinate to, the main purpose of the meeting. This legislation is enforced by the MHRA.

46.3 You must follow your employer’s policy on receiving gifts and hospitality. If you do not have an employer you must consider whether it is appropriate to accept gifts or hospitality in response to your prescribing activities.

PRACTICE GUIDANCE 47: NHS/PRIVATE PRACTICE PRESCRIBING BOUNDARIES

47.1 You must not ask the patient’s GP to prescribe medicines at NHS expense which are subsequently to be administered as part of private healthcare provision. If you do ask a GP to do this, they are within their rights to refuse to do this.

PRACTICE GUIDANCE 48: CHECKING REGISTRATIONS AND ANNOTATIONS

48.1 You should provide evidence of your status as a prescriber annually to your employer / those using your prescribing services.

48.2 You must only prescribe in accordance with the type of annotation awarded to you.
<table>
<thead>
<tr>
<th>Glossary</th>
<th>Definition</th>
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</thead>
<tbody>
<tr>
<td>Administration</td>
<td>Process by which a medicine is introduced into, or applied onto, the patient’s body.</td>
</tr>
<tr>
<td>Advice</td>
<td>The act of giving information to service users pertaining to aspects of the condition for which they are seeking intervention. The information given may be an opinion or recommendation relating to suggested future intervention or actions. The information may include guidance to seek the opinion of another health professional. The information is given to the service user to consider, and the service user may choose whether to act on the advice given or not.</td>
</tr>
<tr>
<td>Appropriate practitioner</td>
<td>Registered professional defined within medicines legislation as being authorised to issue prescriptions for POM class medicines and/or to receive bulk supplies of POM class medicines.</td>
</tr>
<tr>
<td>Black-triangle drugs</td>
<td>New licensed medicines under intensive monitoring by the MHRA and subject to special adverse incident reporting requirements. The MHRA issues a monthly list of medicines subject to Black Triangle status.</td>
</tr>
<tr>
<td>Clinical Governance</td>
<td>Quality assured activities which ensure that pre-determined clinical standards that have been set, are maintained by practitioners, and are evident within health care settings.</td>
</tr>
</tbody>
</table>
| Clinical Management Plan (CMP) | A written plan (which may be amended from time to time) relating to the treatment of an individual patient which is agreed by:  
- The patient  
- The independent prescriber (a doctor or dentist only)  
- The supplementary prescriber who is to prescribe, supply and administer (including delegated administration) |
<table>
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<tr>
<th>Term</th>
<th>Definition</th>
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<tbody>
<tr>
<td>medicines under the plan.</td>
<td>Licensed medicines including off-label and black triangle products, unlicensed medicines and controlled drugs may be included in a CMP. A CMP may be for a named medicine or a group of medicines e.g. non-specified NSAIDs.</td>
</tr>
<tr>
<td>Commissioner</td>
<td>Person or organisation that requests and/or funds a service or activity.</td>
</tr>
<tr>
<td>Competence</td>
<td>The ability of an individual to demonstrate their capability in a certain skill area at a defined level of ability at a set point in time.</td>
</tr>
<tr>
<td>Competencies</td>
<td>The component skills that describe and define the actions and activities required in order to demonstrate competence in a skill area.</td>
</tr>
<tr>
<td>Controlled drug</td>
<td>A medicine subject to control by the Misuse of Drugs Act 1971 and the Misuse of Drugs Regulations 2001.</td>
</tr>
<tr>
<td>CSP</td>
<td>The Chartered Society of Physiotherapy</td>
</tr>
<tr>
<td>Dispensing</td>
<td>To label from stock. The activities undertaken, in response to formal orders, when medicines are issued to the place where they will be used, or supplied directly to the patient.</td>
</tr>
<tr>
<td>Disposal</td>
<td>The removal and disposal of medicines that are no longer required or are no longer suitable for their intended use and/or the removal of unwanted medicines or waste materials from the clinical site.</td>
</tr>
<tr>
<td>GSL</td>
<td>General Sales List. A medicine for which all active ingredients are listed in the relevant Medicines (Products Other Than Veterinary Drugs) (General Sales List) Order, or are so classified in their marketing authorisation.</td>
</tr>
</tbody>
</table>
| Guidance | Document containing recommendations for the use of a particular treatment and/or modality; the circumstances when it should be used and the population/patient groups who should receive it. Health professionals have a duty to take
<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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<tbody>
<tr>
<td>Guidance fully into account where it is published, but they are not bound by its contents and may deviate from it where there is a clear indication to do so. A guidance document may impose a duty on a health provider to fund the treatment and/or intervention.</td>
<td></td>
</tr>
<tr>
<td>Guideline</td>
<td>A wide-ranging recommendation dealing with the management of a disease condition. A guideline document does not impose a duty on a health provider to fund the treatment of the disease condition.</td>
</tr>
<tr>
<td>HPC</td>
<td>Health Professions Council</td>
</tr>
<tr>
<td>Independent prescriber (IP)</td>
<td>A professional who is registered on the appropriate statutory register for their professional group and (for non-doctors) against whose name is recorded an annotation signifying that they are qualified to prescribe, supply and administer medicines as an independent prescriber. A person responsible for the assessment of patients with undiagnosed conditions, and for decisions about the clinical management required including prescribing. They assume full accountability for the prescribing decisions they make. They may instruct another person to administer the medicines under the terms of a PSD. An independent prescriber may be a medical prescriber (doctor/dentist only) or a non-medical independent prescriber (nurse, pharmacist, optomotrist, physiotherapist, podiatrist). The non-medical independent prescribing professions between them do not have the same rights with regard to the use of mixed medicines, unlicensed medicines, and controlled drugs. Medical prescribers have different rights to all non-medical prescribers together.</td>
</tr>
<tr>
<td>KSF</td>
<td>Knowledge and Skills Framework</td>
</tr>
<tr>
<td>Licensed medicine</td>
<td>A medicine with a valid marketing authorisation (product licence) in the UK.</td>
</tr>
<tr>
<td>Term</td>
<td>Definition</td>
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</tr>
<tr>
<td>Marketing authorisation (MA)</td>
<td>Formal approval by the MHRA to place a medicinal product on the UK market, formerly known as ‘product licence’. Defines the terms, conditions and/or patient groups that the product may be used for. Use of a medicine outside of the terms of the MA is known as ‘off-label’ use of the product.</td>
</tr>
<tr>
<td>Medical device</td>
<td>All products, except medicines, used in healthcare for the diagnosis, prevention, monitoring or treatment of illness or disability. Examples include x-ray and other imaging equipment, pacemakers, artificial joints, anaesthetic equipment, infusion equipment, beds, wheelchairs, and surgical dressings.</td>
</tr>
<tr>
<td>Medical prescriber</td>
<td>A doctor or dentist who can independently prescribe both licensed and unlicensed medicines, and who may instruct another health professional to administer such medicines to patients under the terms of a PSD.</td>
</tr>
</tbody>
</table>
| Medicinal product           | Any substance or article (but not instrument, apparatus or appliance) which is manufactured, sold, supplied, imported or exported, for use wholly or mainly in either or both of the following ways:  
  - administration to one or more human beings (or animals) for a medicinal purpose  
  - used as an ingredient, by a practitioner, pharmacy or hospital, in the preparation of a substance or article which is to be administered to one of more human beings for a medicinal purpose. |
| Medicinal purpose           | Any one or more of:  
  - treating or preventing disease  
  - diagnosing disease or ascertaining the existence, degree or extent of a physiological condition  
  - contraception |
<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicine</td>
<td>A substance that claims to, or has the actual function of, treating or preventing disease in humans or animals.</td>
</tr>
<tr>
<td>Mixing</td>
<td>The combining of two or more medicinal products together for the purposes of administering them to meet the needs of a particular patient.</td>
</tr>
<tr>
<td>MHRA</td>
<td>Medicines and Healthcare products Regulatory Agency</td>
</tr>
<tr>
<td>NHS</td>
<td>National Health Service</td>
</tr>
<tr>
<td>NHS prescription charge</td>
<td>Tax paid by patients for medicines or other treatments prescribed for them by an NHS ‘appropriate practitioner’ and supplied at NHS expense. Some patients are exempt from paying prescription charges and receive the medicines free of charge. Prescription charges are set by the Government and do not directly reflect the production costs and/or retail prices of the medicine.</td>
</tr>
<tr>
<td>Non-medical prescriber (NMP)</td>
<td>A nurse, pharmacist and some allied-health professionals who are registered on the appropriate statutory register for their professional group, and against whose name is recorded an annotation signifying they are permitted by the relevant law and qualified to prescribe, supply and administer medicines as either an independent or supplementary prescriber. They can prescribe any licensed or unlicensed medicine for any medical condition including some controlled drugs in certain circumstances. They will be restricted by the British National Formulary, local formularies and local/national guidelines e.g. NICE. An NMP may instruct...</td>
</tr>
</tbody>
</table>
another professional to administer medicines to a patient under the terms of a PSD

<table>
<thead>
<tr>
<th>NPSA</th>
<th>National Patient Safety Agency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Off-label drugs</td>
<td>Use of a medicine outside its licensed indications (as contained within the SPC). Off-label use only applies to medicines that are already licensed i.e. hold a valid Marketing Authorisation.</td>
</tr>
<tr>
<td>Over-the-counter (OTC)</td>
<td>Description of a medicine that can be supplied without a written prescription from a variety of outlets, including self-selection without supervision, by a patient.</td>
</tr>
<tr>
<td>P</td>
<td>Pharmacy Only</td>
</tr>
<tr>
<td>Patient Group Direction (PGD)</td>
<td>A written instruction for the supply or administration of a named medicine in a defined clinical situation to <strong>groups of patients</strong> who may not have been identified before presenting for treatment. In order to be valid, a PGD must meet specific legal criteria. This includes the requirements that only <strong>licensed</strong> medicines are included in a PGD, that the health professional [physiotherapist] named on the PGD is registered with the appropriate statutory regulator [HPC], and that the supply and administration of the drugs listed in the PGD is not delegated to anyone else. PGDs tend to be used in hospital and primary care settings but are also valid in other non-NHS clinical settings. PGDs can include medicinal products for use outside their licensed indications (“off-label”) if their use is exceptional and justified by best clinical practice. Off-label use only applies to medicines that are already licensed. PGDs cannot be used for the administration of pharmacy-prepared products as these are not fully licensed.</td>
</tr>
<tr>
<td>Physiotherapist</td>
<td>A person who is registered on Part 9 of the HPC register under article 5 of the Health Professions Order 2001 and</td>
</tr>
<tr>
<td><strong>entitled to practise using the protected title of 'physiotherapist'</strong>.</td>
<td></td>
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<tr>
<td>---</td>
<td></td>
</tr>
<tr>
<td><strong>POM</strong></td>
<td></td>
</tr>
<tr>
<td>Prescription Only Medicine. Such medicines may only be supplied and administered against a valid written 'prescription'.</td>
<td></td>
</tr>
<tr>
<td><strong>Patient Specific Direction (PSD)</strong></td>
<td></td>
</tr>
<tr>
<td>A written instruction from a doctor, dentist or other independent/ supplementary prescriber for a medicine to be supplied or administered to a <strong>named patient</strong> by another health professional. The patient must be individually identified on the PSD. The written instruction must be signed and dated by the doctor/dentist or other independent/ supplementary prescriber. Unlicensed medicines may be supplied and/or administered under a PSD provided it has originated from an independent prescriber. A PSD is not a standard proforma that is drawn up by a [physiotherapist] for a doctor to sign. This may be one way of indicating the desired prescription, but the doctor is free to amend or alter this in any way as they see fit as they will have accountability for any medicines prescribed.</td>
<td></td>
</tr>
<tr>
<td><strong>Prescribe</strong></td>
<td></td>
</tr>
<tr>
<td><strong>LEGAL</strong>: to request in writing, in the appropriate manner, the supply and administration of a Prescription Only Medicine for use by a named patient. Only 'appropriate practitioners' may prescribe. At the current time for physiotherapists, this is limited to supplementary prescribers.</td>
<td></td>
</tr>
<tr>
<td><strong>GENERAL</strong>: to authorise in writing, in the appropriate manner, the supply and administration of any medicinal product(s), for use by a named patient, at public expense.</td>
<td></td>
</tr>
<tr>
<td><strong>LAY</strong>: to advise on the use of a product, especially by an authorised person or to recommend especially as a benefit.</td>
<td></td>
</tr>
<tr>
<td>Prescribing</td>
<td>Issuing prescriptions for the medical treatment of a single individual by an 'appropriate practitioner'. A pharmacist is legally required to be involved in the sale and/or supply of the medicine identified within a written prescription. Therefore 'prescribing' is a process by which medicines are supplied to a patient involving at least two separate persons – the prescriber and the pharmacist.</td>
</tr>
<tr>
<td>Prescription</td>
<td><strong>LEGAL</strong>: a written instruction by an appropriate practitioner for the supply and administration of the medicinal products listed within it. A written tool against which POM’s may be supplied. A prescription is issued by an ‘appropriate practitioner’ under or by virtue of the National Health Service Act 1977 (England) / the National Health Service (Scotland) Act 1978 / the Health and Personal Social Services (Northern Ireland) Order 1972.</td>
</tr>
<tr>
<td>Product Licence (PL)</td>
<td>Formal approval by the MHRA to place a medicinal product on the UK market. Now known as a ‘marketing authorisation.’ Defines the terms, conditions and/or patient groups that the product may be used for. Use of a medicine outside of the terms of the PL is known as ‘off-label’ use of the product.</td>
</tr>
<tr>
<td>Repeat Prescribing</td>
<td>A partnership between a patient and a prescriber that allows the prescriber to issue duplicate prescriptions at agreed intervals without the patient having to consult the prescriber at each issue.</td>
</tr>
<tr>
<td>Repeatable Prescription</td>
<td>A prescription which authorizes a pharmacist to issue a medicine more than once (e.g supply X medicine every month for six months).</td>
</tr>
<tr>
<td>Standard</td>
<td>A statement on the level of proficiency expected to be demonstrated by a person professing to hold a certain skill or ability. The standards for prescribing are set and regulated by the HPC.</td>
</tr>
</tbody>
</table>
### Summary of product characteristics

(Previously known as the Data Sheet): Information available for individual licensed medicines, forming an integral part of the marketing authorisation (licence). It provides information for health professionals on how to use the medicinal product safely and effectively.

### Supplementary prescriber (SP)

A professional who is registered on the appropriate statutory register for their professional group and against whose name is recorded an annotation signifying they are qualified to prescribe, supply and administer medicines as a supplementary prescriber. A person responsible for the continuing care of patients who have been clinically diagnosed by an independent prescriber.

### Supply

The activities undertaken, in response to formal orders, when medicines are issued to the place where they will be used, or supplied directly to the patient.

### Traditional Herbal Registration (THR) number

MHRA registration scheme for herbal preparations that have been assured for safety, efficacy and quality, i.e. licensing for herbal preparations. Equivalent to a Product Licence for medicines.

### Unlicensed medicine

A medicine that does not have a UK marketing authorisation.
Acknowledgements

The CSP acknowledges the following documents which were informative in the creation of this guidance for physiotherapists.


The CSP acknowledges the guidance and support provided by the individuals from a variety of professions from the Department of Health Project Board for Independent prescribing for Physiotherapists and Podiatrists.

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